Alzheimer's Assisted Living Authorization Request
Virginia Department of Medical Assistance Services

Resident Information					
Last Name		First Name		Middle Name	
Date of Birth (mm/dd/yy)			ALF Secure Unit Admission Date		
Social Security Number			Medicaid Number		

Facility Information					
Name of Facility			Medicaid API Number		
Address of Facility					
City		State		Zip	
Office Number				Fax Number	
Primary Contact		Secondary Contact			
I/We certify that the information contained herein is a true abstract of the resident's condition as documented in the resident's medical record.					
Administrator's Signature			Date		
Signature of Person Completing form			Date		

TO BE COMPLETED BY DMAS

Date Received	Comments:
Approved	Effective Billing Date:
Pend	
Denial	

Signature and Date: _____
DMAS Representative:

Please return this completed form to:
DMAS Division of Long Term Care & Quality Assurance
600 East Broad Street, Suite 1300 Richmond, VA 23219
Or
Fax to: (804) 612-0040